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No. _____

Supreme Court, U.S.
FILED
MAR 2 1987
JOSEPH F. SPANIOL, JR.
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1986

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,

Petitioners,

v.

COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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QUESTIONS PRESENTED

1. May health care providers and their patients bypass state remedies and sue under 42 U.S.C. § 1983 to challenge state Medicaid reimbursement decisions when, pursuant to the express directives of the Medicaid Act and federal implementing regulations, the state has established administrative procedures specifically to address those claims?

2. Do the rate reimbursement provisions established by the states as part of their state Medicaid plans give rise to federal rights enforceable under 42 U.S.C. § 1983?

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PETITION FOR WRIT OF CERTIORARI

Petitioners, the Department of Human Resources of the State of Oregon, and Richard C. Ladd, Administrator of the Senior Services Division of the Department of Human Resources, (hereinafter "the state"), respectfully pray that this Court issue a writ of certiorari to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit in *Coos Bay Care Center v. State of Oregon, Department of Human Resources*, No. 85-4049 (November 3, 1986).

OPINIONS BELOW

The opinion of the Ninth Circuit Court of Appeals is reported as *Coos Bay Care Center v. State of Oregon, Department of Human Resources*, 803 F.2d 1060 (9th Cir. 1986), and is attached to this petition as Appendix A. The order and judgment of the district court is unreported, and is attached as Appendix B. The magistrate's Findings and Recommendations are also unreported, and are attached as Appendix C. The magistrate relied substantially upon the earlier decision of the District Court of Oregon in *Beecroft v. Atiyeh*, Civil No. 78-1027-BU (1982) which is also unreported and is attached as Appendix D.

JURISDICTION

The opinion of the Ninth Circuit Court of Appeals was dated and filed on November 3, 1986. The judgment sought to be reviewed was entered on the same date. Jurisdiction to review the judgment in this civil case by writ of certiorari is conferred upon this Court by 28 U.S.C. § 1254(1) (1982). This petition for writ of certiorari is filed within the time allowed by order of this Court dated January 20, 1987, which extended the time for filing this petition to March 3, 1987.

STATUTES AND REGULATIONS INVOLVED

1. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* (1982), provides, in pertinent part:

§ 1396 For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

§ 1396a(a) A State plan for medical assistance must—

. . . .

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

. . . .

(13) provide—

(A) for payment . . . of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State) . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality

. . . .

. . . .

(37) provide for claims payment procedures which . . . (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

2. 42 U.S.C. § 1983 (1982) provides in pertinent part:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. . . .

3. 42 C.F.R. § 431.220(a) provides:

(a) The agency must grant an opportunity for a hearing to:

(1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness; and

(2) Any recipient who requests it because he believes the agency has taken an action erroneously.

4. 42 C.F.R. § 431.241 provides:

The hearing must cover—

(a) Agency action or failure to act with reasonable promptness on a claim for services, including both initial and subsequent decisions regarding eligibility; and

(b) Agency decisions regarding changes in the type or amount of services.

5. 42 C.F.R. § 431.246 provides:

The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, if—

(a) The hearing decision is favorable to the applicant or recipient; or

(b) The agency decides in the applicant's or recipient's favor before the hearing.

6. 42 C.F.R. § 447.253(c) provides:

(c) *Provider appeals.* The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

STATEMENT OF THE CASE

Plaintiff Coos Bay Care Center (hereinafter "CBCC") is an intermediate care facility that provides long-term health care services for the developmentally disabled and the aged. (Findings and Recommendation, Appendix C at App-10). CBCC participates as a health care provider in Oregon's Medicaid program. (*Id.*). The individual plaintiffs are resident patients at CBCC. (Complaint, Appendix E at App-32). Defendant Oregon Department of Human Resources (hereinafter "DHR") is the Oregon state agency responsible for administering the state's Medicaid program. (*Id.*). Defendant Richard C. Ladd is the Administrator of the division of the DHR which directly administers Oregon's Medicaid program. (*Id.*).

Plaintiffs initiated litigation on their own behalf and on the behalf of others similarly situated by filing a complaint under 42 U.S.C. § 1983 seeking damages, injunctive and declaratory relief and certification as a class action. Plaintiffs alleged that defendants failed correctly to classify certain patients (including the individual plaintiffs) as "heavy cost" care patients and, accordingly, failed to reimburse plaintiff CBCC at the special rate applicable under Oregon's Heavy Cost Program for care of those patients. (*Id.* at App-34 - 35.)

Oregon's Heavy Cost Program is narrowly defined by state administrative rules. To be eligible under the rules, patients

must be functional quadriplegics "ready for discharge from an acute care hospital or whose care could be provided in a nursing facility in lieu of placement in an acute care hospital." Or. Admin. R. 411-70-030(1)(b). The special heavy cost reimbursement rate is expressly identified as an "add-on to the facility's established rate for the clients' level of care." Or. Admin. R. 411-70-030(7)(b).[1]

A facility's established rate for care provided to all patients under Oregon's Medicaid program is determined under the provisions of a separate administrative rule that defines an all-inclusive rate for "all services, supplies and facility equipment required for care." Or. Admin. R. 411-70-085(1)[2] The state has further established the 75th percentile as the rate appropriate to reimburse reasonably an efficiently and economically operated facility. Or. Admin. R. 411-70-440.[3] Accordingly, under Oregon's plan, if a facility's claimed costs for providing the services included in the all-inclusive or established rate fall within the lower 75 percent of costs incurred by all eligible facilities, Oregon reimburses the facility for all of its claimed costs. But if its claimed costs are greater than the costs incurred by those within the lower 75th percentile, Oregon reimburses the facility only at the 75th percentile rate.

The "established rate," thus, is the standard reimbursement rate contained in Oregon's Medicaid plan and approved by the Secretary of the United States Department of Health and Human Services as the rate that adequately will reimburse efficiently operating facilities for services provided to Medicaid patients. The special add-on "heavy cost" reim-

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[1] Or. Admin. R. 411-70-030(1) and (7) are set out in full in Appendix F.

[2] Or. Admin. R. 411-70-085(1) and (2) are set out in full in Appendix G.

[3] Or. Admin. R. 411-70-440 is set out in full in Appendix H.

bursement rate provides complete reimbursement through a special daily rate for services provided to patients who meet the particularized requirements of the Heavy Cost Program.

Plaintiffs' complaint did not claim that Oregon's Medicaid plan itself violates federal law, or that the established rate capped at the 75th percentile level fails to reimburse health care providers at a rate adequate and reasonable to meet the costs which efficiently and economically operated facilities must incur, the standard imposed by 42 U.S.C. § 1396a(a)(13)(A). Rather, plaintiffs' complaint alleged only that certain patients whom plaintiffs contend meet the qualifications of the state's Heavy Cost Program have been denied eligibility for that program. (Complaint, Appendix E at App-34 - 35). Upon this basis, plaintiffs sued the state complaining that defendants' failure to treat certain patients as "heavy cost" patients violated state law and Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.*

The case was assigned to a United States Magistrate for findings and recommendations. On the facts alleged, Magistrate Hogan determined that 42 U.S.C. §§ 1396 *et seq.* did not create enforceable rights or a private right of action and that plaintiffs, therefore, could not sue under 42 U.S.C. § 1983. The District Court of Oregon, Honorable Judge Burns, adopted the magistrate's findings and recommendations and dismissed plaintiffs' complaint with prejudice and without leave to amend.

Plaintiffs appealed to the Ninth Circuit Court of Appeals. The Ninth Circuit held that plaintiffs' complaint stated a claim for statutory entitlement cognizable under 42 U.S.C. § 1983. The Ninth Circuit, therefore, reversed and remanded this case for further proceedings.

REASONS FOR GRANTING THE WRIT

The Ninth Circuit's determination that plaintiffs' allegations raise federal rights enforceable under 42 U.S.C. § 1983 has jarring implications for federal-state relations in the administration of cooperative funding programs. Although the issues arise in the particular context of the Medicaid program established by Title XIX of the Social Security Act, they transcend the narrow setting of this particular statutory scheme.

In determining what remedies Congress intended to make available for enforcement of the Medicaid program, the Ninth Circuit declares it *irrelevant* that: (1) Congress in the enactment expressly requires the states to establish corrective administrative processes; (2) those processes must be reviewed and approved by the federal government; (3) states devote considerable resources to providing administrative remedies tailored to resolve the very claims plaintiffs seek to adjudicate in federal court; and (4) those are the only remedies expressly contemplated by the congressional enactment and federal implementing regulations. Moreover, the Ninth Circuit silently accepts the proposition that Congress intends the creation of *federal* rights even when Congress itself declines to set specific levels of benefits under the scheme and instead purposely calls on the states to exercise independent judgment and discretion to create specific entitlements. In accepting that proposition, the lower court's decision ignores the serious Eleventh Amendment concerns raised. The result in this case is disturbing, not only because it upsets the cooperative balance struck by Congress and effectively robs the states of their contemplated role, but also because the Ninth Circuit reaches this result on such barren analysis.

This Court's decisions should have guided the Ninth Circuit in charting a true course. In *Maine v. Thiboutot*, 448

U.S. 1 (1980) this Court held that 42 U.S.C. § 1983 was available to enforce state violations of federal statutes. Since that decision, both this Court and lower courts have grappled with the outer limits of that holding. Although *Thiboutot* arguably could be read to permit recourse to a § 1983 action for any violation of federal statute (*see, e.g.*, dissenting opinion of Powell, J., in *Maine v. Thiboutot*), subsequent decisions have established that § 1983 enforcement of federal statutes is a more limited proposition. *See, e.g., Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1 (1981) (*Pennhurst I*) and *Middlesex County Sewerage Authority v. National Sea Clammers Assn.*, 453 U.S. 1 (1981) (*Middlesex*) (§ 1983 is not available to remedy statutory violations where Congress has foreclosed such enforcement in the enactment itself or where the statute does not create rights within the meaning of § 1983). The key to the inquiry is congressional intent, and the analysis should turn on a meaningful search for that intent. *See generally Wright v. City of Roanoke Redevelopment and Housing Authority*, ___U.S. ___, 107 S. Ct. 766 (1987). Since *Thiboutot*, this Court has suggested that the number of statutory enactments enforceable through § 1983 are few, rather than many. *See Garcia v. Wilson*, 471 U.S. 261, 278-79 (1985).

To date, this Court has not addressed the availability of § 1983 to adjudicate rate reimbursement disputes under the federal Medicaid program. Nor has the Court, in determining § 1983 jurisdiction, considered the significance of the existence of congressionally mandated state administrative remedies approved by the United States Department of Health and Human Services and the question whether claims brought under the state-crafted provisions of public aid plans invoke federal rights.

Resolution of these questions by this Court is important because the states, all of which participate in the Medicaid program, are entitled to know the scope of their exposure to

suit in federal court. Additionally, lower federal circuit and district courts need guidance in this area. Judicial responses to § 1983 actions brought to adjudicate rate reimbursement disputes under the Medicaid Act are differing and confused, and the case results are frequently at odds. For these reasons, this Court should grant certiorari.

I

A. The Ninth Circuit's wholesale disregard of Oregon's administrative remedies frustrates the spirit and purpose of the cooperative Medicaid scheme.

1. *The Medicaid Structure*

The Medicaid program is a cooperative federal-state fund matching scheme set up to provide medical services to the poor.[4] One of the important components of the program is the assistance provided indirectly to institutionalized patients through funds channeled to long-term care facilities (LTCF's). This is achieved by reimbursing LTCF's at a rate established by each individual state and approved by the Department of Health and Human Services Health Care Financing Administration (HCFA). 42 U.S.C. §§ 1396, 1396a(a)(13)(A).

Under the program, primary responsibility for development and administration of a Medicaid plan rests with the individual states. Within the limits of the Medicaid Act and the implementing regulations, each state determines eligibility requirements for the program, develops criteria for qualifying health care providers, determines the scope and duration of services provided to patients, and sets rates for reimbursement. *See generally Briarcliff Haven, Inc. v. Dep't of Hum.*

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[4] Federal requirements for the program are set out in Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 - 1396p.

Res., Ga., 403 F. Supp. 1355, 1358 (N.D. Ga. 1975) and discussion therein.

State discretion regarding the content and scope of the state's plan gradually has expanded with the Medicaid Act's evolution. This is particularly so in the setting of reimbursement rates for LTCF's. Originally, states were required to reimburse LTCF's for inpatient services on the basis of cost methodology used by the federal Medicare program. *Mississippi Hosp. Ass'n, Inc. v. Heckler*, 701 F.2d 511, 515 (5th Cir. 1983). In 1972, in response to concerns about spiraling costs, Congress amended Title XIX by insertion of a "reasonable cost related standard" for reimbursement designed to allow, and even encourage, each state to develop its own alternative reimbursement scheme *Id.*[5] In 1980, Congress replaced that standard with the current requirement that each state develop reimbursement rates that the state finds, and the federal oversight agency agrees, are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . ." 42 U.S.C. § 1396a(a)(13)(A) (as amended by the Omnibus Budget Reconciliation Act of 1980, Public Law 96-499, § 962). This amendment was designed to expand even further the states'

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[5] *See* Public Law 92-603, § 249. With the 1972 amendment, Congress substantially broadened state administrative discretion. As discussed in *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 392 (5th Cir. 1980):

> Congress intended that state authorities in developing methodologies for reasonable cost related reimbursement have great flexibility in the areas of cost-finding and rate-setting. The legislative history indicates that states are to be free to experiment with methods and standards for payment that would be simpler and less expensive than the complex Medicare reasonable cost formula. See S.Rep. No. 92-1230, 92d Cong., 2d Sess. 287 (1972). . . . Additionally, Congress intended that states have freedom both to define allowable cost items and to set a value on the reasonable cost of such items.

discretion in developing and implementing reimbursement methodologies.[6]

State plans thus are highly individualized and variable. Each state exercises primary authority over the contents and the administration of its plan. HCFA possesses responsibility for reviewing and approving a state's proposed plan. But in meeting this responsibility the federal agency has acknowledged the essential role of state discretion in areas such as reimbursement rate-setting. *See* 48 Fed. Reg. 56047 (December 19, 1983).

Consistent with the states' role, Congress and HCFA have mandated the existence of certain administrative structures at the local level. For example, each state must administer its plan through a special state agency. 42 U.S.C. § 1396a(a)(5). Of particular relevance here, states also must establish administrative hearing processes for patient benefit challenges and a provider appeals process for reimbursement decisions. 42 U.S.C. §§ 1396a(a)(3) and 1396a(a)(37); 42 C.F.R. §§ 431.220, 431.241, 431.246 and 447.253(c). Because state plans vary so widely, HCFA leaves it to the states to determine the precise appeal procedures that will best comple-

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[6] The "Boren Amendment" standard was extended to hospitals as well as other long-term care facilities in 1981. Public Law 97-35, § 2173. As the legislative history reflects:

> In eliminating the current requirement that States pay hospitals on a Medicare "reasonable cost" basis for inpatient services under Medicaid, the Committee recognizes the inflationary nature of the current cost reimbursement system and intends to give States greater latitude in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of such services.

H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981).

ment their chosen reimbursement system.[7] But, pursuant to Congress' mandate in the Medicaid Act, HCFA reviews and approves the state's adopted administrative procedures in approving the state plan. 42 U.S.C. § 1396.

The "right" granted under the federal enactment is, accordingly, not just the right to funding for medical costs; it includes also the right to a state forum to challenge state reimbursement decisions. The Ninth Circuit is thus flatly wrong in its statement that "Title XIX *permits* states to establish administrative review procedures for disputes over Medicaid reimbursements." 803 F.2d at 1062 (emphasis added). The lower court is equally wrong in its characterization of the state administrative remedies as "complementary." 803 F.2d at 1062, n. 2. State administrative remedies are *required* under the Medicaid program. Those remedies are reviewed and approved by HCFA as a condition of state participation in the program. As the only remedy expressly provided for by Congress and approved by HCFA, the state remedies certainly must be deemed primary.

2. *The Oregon Administrative Hearing and Review Structure.*

Oregon's administrative review procedures comply fully with the federal mandate, evidencing Oregon's commitment

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[7] In commenting on the regulations requiring provider appeals of state rate determinations, HCFA concluded that "the States, not the Federal government, are in the best position to determine the administrative process that would best meet their needs and be most compatible with the reimbursement system. *See* 48 Fed. Reg. 56047 (December 19, 1983). As the agency further noted:

> Since the Medicaid program is State administered, it is neither appropriate nor administratively feasible to establish a Federal appeals process outside the current State administrative procedures or the State and Federal civil court systems. Finally, absent any statutory mandate, there is no Federal authority to require judicial recourse (presumably in State courts) for providers dissatisfied with State payment rates. Of course, under both the current and revised regulations, providers are free to pursue whatever judicial remedies are available in their States after they have exhausted the administrative appeal process.

Id.

to its responsibility for administering its plan and its interest in ensuring correct administrative decisions. By administrative rule, health care providers and facility residents may challenge agency reimbursement and benefit decisions and receive administrative review.[8] If they are dissatisfied with the results of the administrative process, they can further adjudicate their claim in state court pursuant to the Oregon Administrative Procedures Act, Or. Rev. Stat. ch. 183.[9] Thus, providers and patients aggrieved by state benefit and reimbursement decisions may seek correction of those decisions through both administrative and judicial remedies available at the state level as a matter of right.

3. *By-Pass of State Administrative Remedies Frustrates the Medicaid Program.*

The state argued to the Ninth Circuit that the federally mandated existence of a comprehensive state remedial scheme was a key factor in determining Congress' intent and, thus, the availability of a § 1983 remedy in this case. The Ninth Circuit casually dismissed that argument in a footnote, declaring that the availability of a state administrative remedy was "not relevant." 803 F.2d at 1062, n. 2. Such cavalier disregard of the existence of remedies placed by design into the statutory scheme offends common sense and is legally unsound. The fact that Congress required states to provide

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[8] *See, e.g.*, Or. Admin. R. 461-09-000 (Fair Hearing Definitions), Or. Admin. R. 461-09-010 (The Hearing Request), Or. Admin. R. 461-09-011 (Group Fair Hearings), and Or. Admin. R. 411-70-435 (Provider Appeals). These administrative rules are set out in Appendix I.

[9] Oregon by statute has provided for judicial review of administrative agency decisions, if a party wishes to contest the agency decision. The provisions contained in Or. Rev. Stat. §§ 183.482 and 183.484 are set out in Appendix J.

administrative remedies is a legitimate guide in the inquiry into congressional intent. *Cf. Wright v. City of Roanoke Redevelopment and Housing Authority*, ___ U.S. ___, 107 S. Ct. 766, 771 (1987) (centralization of enforcement authority and existence of comprehensive remedial mechanisms are relevant to Congress' intent to foreclose § 1983 remedy).

The Medicaid enactment establishes a true cooperative state-federal funding scheme in which both sovereigns contribute resources to achieve a common goal. Congress' intent, reflected in the scheme's very structure, is that state administrative errors be corrected promptly by the state. When, as here, Congress and the federal agency have mandated the existence of state corrective remedies, Congress' intent necessarily is that those remedies be used. However, the necessary consequence of the Ninth Circuit's ruling is that providers and patients need never avail themselves of those state processes.

Congress' desire to have rate reimbursement challenges litigated at the state level is underscored by its repeal, in 1976, of a provision of the Medicaid program requiring participating states to waive immunity to federal court suits brought by providers. 42 U.S.C. § 1396(g) (repealed).[10] Congress' rationale in repealing the provision was to avoid an "unreasonable burden of suits . . . which will make efficient program administration virtually impossible." *Hosp. Ass'n of New York v. Toia*, 435 F. Supp. 819, 825 (S.D. N.Y. 1977). More-

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[10] 42 U.S.C. § 1396(g) (repealed) provided:

> Notwithstanding any other provision of this title, a State plan for medical assistance must include a consent by the State to the exercise of the judicial power of the United States in any suit brought against the State or a State officer by or on behalf of any provider of services (as defined in section 1861(u)) with respect to the application of subject (a)(13)(D) to services furnished under such plan after June 30, 1975, and a waiver by the State of any immunity from such a suit conferred by the 11th amendment to the Constitution or otherwise.

over, Congress seriously questioned the constitutionality of a provision waiving the states' Eleventh Amendment immunity. *Id.* at 824. Thus, the Ninth Circuit's decision contravenes the Medicaid program's history, as well as its current structure.

The result reached in this case similarly frustrates state expectations and interests. To discount a comprehensive state remedial scheme as irrelevant shows no respect for the central role of each state in administering its state plan. States develop their plans, staff their agencies and implement their administrative processes at substantial expense. As one of two sovereigns in the compact, each state has an interest at least equal to that of the federal government in correcting errors in a plan's administration. Given their primary role in fashioning and implementing the plans, the states' interests in fact are weightier. When a state invests its efforts and resources to implement remedial processes specifically contemplated by the federal act, the state, too, is entitled to expect that those processes will be used. It is an affront to the integrity of those state processes and the sincerity of the states' efforts to suggest that state administrative remedies are not worth consideration.

The Ninth Circuit's holding widely opens federal court doors to these claims and threatens a severe burden on state resources and on federal court dockets. Rate reimbursement decisions are not one-time events. Providers are reimbursed for their costs on a periodic basis, often annually or semi-annually. Litigating these periodic decisions through § 1983 actions will heavily tax federal district courts and state resources. Imposing the heavy cost of federal court litigation on the states is particularly unfair when, at federal behest, they have also borne the burden of establishing a state remedial scheme that resolves reimbursement disputes more

rapidly and does not pose Eleventh Amendment impediments to complete relief. *Dep't of Health v. Florida Nursing Home Ass'n*, 450 U.S. 147 (1981) (Eleventh Amendment bars suit in federal court for retroactive Medicaid payments). Ultimately, because this holding means that state administrative remedies either will sit idle or prove merely duplicative, the result is wasteful as well.

B. Lower federal courts have reached different conclusions on the availability of § 1983 relief for alleged Medicaid rate violations under divergent analyses that demonstrate the need for this Court's guidance.

Congressional intent is and should be the polestar in determining the availability of § 1983 relief for an alleged violation of federal statute. The Ninth Circuit, however, made little effort to search for that intent. It concluded first that *Maine v. Thiboutot* governs all actions to enforce any provision of the Social Security Act and that *Pennhurst I*, *supra*, and *Middlesex*, *supra*, are inapplicable. 803 F.2d at 1061. However, apparently as a cautionary measure, the lower court undertook a *Pennhurst I* analysis. Congress' intent, the court concluded, was not to foreclose a § 1983 action since no judicial or federal administrative remedies were expressly mandated. The court also found the rights at stake to be of the kind enforceable under § 1983, for providers and patients alike. 803 F.2d at 1062-63.

The Ninth Circuit is not alone in its analysis. Other courts, too, have read the *Thiboutot* decision broadly to sanction § 1983 actions brought to enforce any provision of the Social Security Act. Some of these decisions fail altogether to discuss the limiting doctrines of *Pennhurst I* and *Middlesex*. *E.g.*, *Mitchell v. Johnson*, 701 F.2d 336, 344 (5th Cir. 1983); *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291, 1295-96 (8th Cir. 1985) *cert. denied*, ___ U.S. ___, 107 S.

Ct. 947 (1987). At least one other federal court has held that suits to enforce the Medicaid statute are generally unaffected by the *Pennhurst I* decision. *In re Greenwald*, 603 F. Supp. 45, 51-52 (S.D. N.Y. 1984).

A substantial body of federal authority has reached a directly opposite result, however. Although these courts have not done so under a *Pennhurst I* analysis, they have meaningfully inquired into the spirit and purpose of the Medicaid act and have resolved the issue in a way calculated to effectuate congressional intent.

Several lower federal courts have held that available administrative remedies must be exhausted before bringing a federal court action to enforce the Medicaid program. They have imposed this requirement pursuant to *Parratt v. Taylor*, 451 U.S. 527 (1981), where, as here, plaintiffs cast their claims exclusively or alternatively as due process denials. *See, e.g., Oberlander v. Perales*, 740 F.2d 116, 120-22 (2d Cir. 1984). Other courts have required exhaustion pursuant to traditional principles of comity and judicial economy. *See, e.g., Al-Charles, Inc. v. Heintz*, 620 F. Supp. 327, 331 (D.C. Conn. 1985).[11] As explained by one district court in rejecting, in this context, the general rule that exhaustion is not a prerequisite to § 1983 claims:

> [T]he *Patsy* [*v. Board of Regents*, 457 U.S. 496 (1982)] doctrine should not apply to a case when the lawsuit arises out of federal statutes enacted after § 1983 which contemplate or require that the state will institute or provide administrative review procedures. . . . In this case, the Medicaid Act expressly

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[11] *See also Arden House, Inc. v. Heintz*, 612 F. Supp. 81, 85-86 (D.C. Conn. 1985); *St. Joseph Hosp. v. Electronic Data Systems Corp.*, 573 F. Supp. 443, 450 (S.D. Tex. 1983); *Ryans v. New Jersey Commission for the Blind*, 542 F. Supp. 841, 850 (D. N.J. 1982); *Fuzie v. Manor Care, Inc.*, 461 F. Supp. 689, 696 (N.D. Ohio E.D. 1977).

> contemplates administration and management of the Medicaid Program by the states. *See e.g.*, 42 U.S.C. § 1396a(a)(4,5). If we were to accept the Plaintiffs' arguments to the contrary, the exhaustion requirement embodied in both the Texas and federal Administrative Procedure Acts would be reduced to meaningless charades since those Acts could be circumvented by merely "crying 1983." We decline to do so.
>
> The exhaustion doctrine contemplates that the real issues in controversy be presented to the administrator, that he be given the opportunity to apply his special skills and experiences to them, that he be permitted to correct errors and that resort to the courts be had only thereafter. . . . This set of considerations forms the crux of the exhaustion requirement.

St. Joseph Hosp. v. Electronic Data Systems, supra, 573 F. Supp. at 450. As another district court has observed, any other result would be inconsistent with Congress' intent to dissuade suits in federal court as evidenced by the repeal of the Medicaid provision requiring state waiver of immunity. *Arden House, Inc. v. Heintz, supra*, 612 F. Supp. at 85-86. But, concededly, lower federal court authority is split on whether exhaustion principles should apply. *See, e.g., Alacare, Inc.-North v. Baggiano*, 785 F.2d 963, 967-70 (11th Cir. 1986); *In re Greenwald*, 603 F. Supp. 45, 51-52 (S.D. N.Y. 1984).[12]

Additionally, some federal courts have dismissed § 1983 actions brought to enforce Medicaid claims under the abstention doctrine of *Burford v. Sun Oil*, 319 U.S. 315 (1943). *See, e.g., New York State Ass'n. for Retarded Children v. Carey*, 727 F.2d 240, 245 (2d Cir. 1984); *Arden House, Inc. v. Heintz*,

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[12] *See also Colorado Health Care Ass'n. v. Colorado Dept. of Soc. Serv.*, 598 F. Supp. 1400, 1406 (D. Colo. 1984); *Georgia Hospital Ass'n v. Dept. of Med. Assistance*, 528 F. Supp. 1348, 1353 (N.D. Ga. 1982); *Mendoza v. Lavine*, 412 F. Supp. 1105, 1108-10 (S.D. N.Y. 1976).

supra, 612 F. Supp. at 86; *St. Joseph Hosp. v. Electronic Data Systems*, *supra*, 573 F. Supp. at 451-52. In doing so, these courts have demonstrated sound respect for the sovereignty of the states and their contemplated role under the cooperative state-federal Medicaid program:

> *Burford* abstention is proper when a state has established an administrative framework to formulate policy and decide cases in an area of legitimate state interest. The underlying tenets of abstention are rooted in the fundamental concepts of federalism which require the federal judiciary to refrain from hearing matters in the first instance which directly involve important state interests in order to maintain proper harmony in state-federal relations. . . .
>
> In the instant case the Medicaid Act has established a cooperative state-federal program wherein the states actually administer and oversee the payment of benefits and related matters. The State of Texas has erected an elaborate system for the administration of the program. We are therefore of the opinion that this case is one where *Burford* abstention is proper.

St. Joseph Hosp. v. Electronic Data Systems, *supra*, 573 F. Supp. at 451-52 (citations omitted).

This canvas of lower federal court cases shows that federal court decisions embody no consensus on whether or when to hear § 1983 actions asserting rights under Title XIX. However, there is one point about which there can be no dispute: Congress designed the Medicaid program so that administrative errors could be promptly corrected at the state level; Congress, therefore, must have intended for those procedures to be used. To ignore state remedies, or to cast them aside as inconsequential, directly undermines the congressional design. Yet, that is precisely the effect of the Ninth Circuit's decision in this case. Although other federal courts have reached results more in line with Congress' manifest intent, they have followed disparate analyses. This Court's

review is required in this case to bring clarity and order to an area of the law which currently stands in disarray.

II

As discussed at length in the prior section, states have the central responsibility to determine the type and amount of the benefits they will provide at the local level. With respect to reimbursement rates in particular, the federal enactment provides only that a state must use rates that the state finds are reasonable and adequate to meet the costs which must be incurred by an efficient and economically operated facility. 42 U.S.C. § 1396a(a)(13)(A). The particular rates set for specific categories of medical care unquestionably are, under the federal enactment, matters within each state's sound discretion.

The significant issue raised by this statutory structure is whether claims based on entitlements under state rate provisions, as opposed to the express provisions of the Medicaid Act itself, involve *federal* rights enforceable through a § 1983 action. Here, plaintiffs sought reimbursement for "heavy cost" services to certain Medicaid patients, a category of services that the State of Oregon has chosen to fund at a particularly high rate. Their complaint *alleged* a violation of the federal Medicaid statute. But, as the district court observed, the only state action or inaction identified was the state's asserted failure to reimburse at the state plan "add on" rate for heavy cost care, as established by state administrative rule.[13]

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[13] The magistrate below accurately described the gravamen of plaintiffs' complaint:

> [P]laintiffs' complaint contends that under the applicable state regulation and a contract with the state of Oregon Department of Human Resources, plaintiff Coos Bay Care Center is entitled to more money for the services it renders to certain heavy care

(Footnote continued on next page)

Members of this Court recently have questioned whether administrative regulations, as opposed to the underlying congressional enactment they implement, can be said to create rights enforceable under § 1983. *Wright v. City of Roanoke Redevelopment and Housing Authority, supra*, 107 S. Ct. at 775 (O'Connor, J., dissenting, joined by Rehnquist, C.J., Powell and Scalia, J.J.). The dissent in *Wright* also questioned whether regulations create judicially manageable standards, and are thus actionable under § 1983, when they direct only "reasonable" levels of benefits and delegate specific delineation of entitlements to local administrators. *Id.* at 778.

Whatever the answers may be to those difficult questions when a *federal* agency's regulations are the putative source of a claimed right and when discretion is delegated to federal administrative bodies, the problem takes on a new dimension in a federal-state cooperative program like Medicaid. The questions must be asked: How can Congress have intended to create *federal* rights when the authority to design specific entitlements rests with the independent sovereign states? How can that intent be imputed to Congress when Congress expressly deferred to *state* discretion and judgment in the development of state Medicaid plans? Did Congress intend federal courts to be placed in the position of second-guessing state discretion under the broad reasonableness standard of Title XIX?

(Footnote continued from previous page)

> Medicaid patients, who by virtue of their medical or developmental problems require significantly more care that [*sic*] the ordinary intermediate patient. OAR 411-70-030 provides *inter alia* for specific and complete reimbursement of costs for providing heavy care. The individual plaintiffs contend that they are among the "heavy care" patients residing within the Coos Bay Care Center and elsewhere who qualify for heavy care but do not receive the full range of appropriate care because of defendants' alleged refusal to appropriately reimburse health care providers for such care.

Findings and Recommendations, Appendix C at App-11).

These questions, however, were never asked or answered by the Ninth Circuit. For the Ninth Circuit, it was enough to conclude that the statutory scheme was enacted for the special benefit of the plaintiff or plaintiff class. 803 F.2d at 1063. But states do not act as mere administrative arms of the federal government. In this, as in any cooperative federal-state funding scheme, they are partners with sovereign status seeking jointly with the federal government to further a common objective. The Ninth Circuit's resolution of the issue is simply inadequate.

State participation in the cooperative scheme adds a constitutional dimension to the analysis. In the Ninth Circuit, the state argued that because plaintiffs' allegations arise under state regulations rather than under the federal Medicaid Act itself, the Eleventh Amendment protects the state from suit in federal court. The Ninth Circuit declined even to address that argument.

Although the problem never has been discussed by this Court, it unquestionably is a substantial issue that merited the Ninth Circuit's careful consideration and resolution. In *Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89 (1984) (*Pennhurst II*), this Court declared that the Eleventh Amendment bars a federal court's grant of relief against state officials on the basis of state law, whether the relief sought is prospective or retroactive. That holding was driven by the recognition that federal court coercion of state action cannot, in such an instance, be justified by the need to vindicate the supreme authority of federal law. *Id.* at 106. This Court found it difficult to envision a "greater intrusion" on state sovereignty than when a federal court instructs state officials how to conform their conduct to state law; it therefore would not, consistent with principles of federalism, tolerate that intrusion. *Id.*

At least one circuit court has concluded that claims seeking to enforce a state's compliance with its own Medicaid

plan raise questions of state law only, not federal law. In *Oberlander v. Perales*, *supra*, plaintiffs argued that reduction of their Medicaid reimbursement rate violated a state rate regulation. Plaintiffs further reasoned that because the state plan must conform with the federal Medicaid statute, there was *ipso facto* a violation of federal law. The United States Court of Appeals for the Second Circuit held:

> We reject this tortuous argument, which, if valid, would provide a jurisdictional basis for federal judicial review of every disputed state administrative ruling relating to Medicaid. " '[S]uits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act on the part of participating States,' " *Maine v. Thiboutot*, 448 U.S. 1, 4, 100 S.Ct. 2502, 2504, 65 L.Ed.2d 555 (1980) (quoting *Edelman v. Jordan*, 415 U.S. 651, 675, 94 S.Ct. 1347, 1362, 39 L.Ed.2d 662 (1974)), but there is no authority anywhere supporting the proposition that a state Medicaid regulation becomes a federal law merely by virtue of its inclusion in a state plan required by federal law. To the contrary, every precedent cited by Flatbush Manor has involved allegations of a specific conflict between a state plan or practice on the one hand and a federal mandate on the other. . . . Since Flatbush Manor alleges no such conflict between the state plan and federal law, we dismiss the statutory claim.

Oberlander v. Perales, *supra*, 740 F.2d at 119 (citations omitted).

Here, as in *Oberlander*, plaintiffs did not base their claim on a conflict between the state plan and federal law. Their complaint sought a reimbursement rate set by Oregon for "heavy cost" care. The structure of the Medicaid Act belies any assertion that a federal mandate guarantees a particular amount of compensation for that care. Under the Second Circuit's analysis, therefore, the federal court lacked jurisdiction to adjudicate that claim.

The result in this case is squarely at odds with the law in the Second Circuit; the conflict needs resolution. The *Oberlander* decision correctly observes that if every provision of a state's Medicaid plan is deemed to give rise to a federal right within the meaning of § 1983, then all disputed state administrative decisions can be adjudicated in federal court. That conclusion plainly runs afoul of the contemplated role of the states in administering the Medicaid scheme. More important, it cannot be harmonized with the federalism principles discussed in *Pennhurst II*, *supra*. Federal court intrusion here is not necessary to vindicate important federal rights; Congress has declined to create federally any particular rate structure. Instead, Congress views the contents of a state's Medicaid plan, including reimbursement rates, as an area of primary state interest and concern. To permit, as the Ninth Circuit permits, federal courts to instruct state officials on how to conform their conduct to the state-created terms of their individual Medicaid plans has deeply disruptive implications for correct federal-state relations. This Court should grant certiorari to examine the Ninth Circuit's ill-advised course.

CONCLUSION

For the reasons given above, the Court should issue a writ of certiorari to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted,

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APPENDIX A

COOS BAY CARE CENTER, an Oregon Corporation; Hannah Schwanke, Guardian Ad Litem for David and Steven Schwanke, et al., Plaintiffs-Appellants

v.

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; Richard C. Ladd, Defendants-Appellees.

No. 85-4049.

United States Court of Appeals, Ninth Circuit.

Argued and Submitted Sept. 4, 1986.
Decided Nov. 3, 1986

[Names of counsel omitted in printing]

Before WRIGHT, GOODWIN, and NELSON, Circuit Judges.

GOODWIN, Circuit Judge:

A long-term health-care facility and several of its patients sued state defendants complaining that the state was violating both state laws and Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396q (1982 & Supp. III 1985). The Senior Services Division of the State of Oregon withheld from plaintiffs certain "heavy-care" Medicaid payments and reimbursements. The district court dismissed the action for failure to state a claim. Fed. R. Civ. P. 12(b)(6). Because a cognizable claim for statutory entitlement has been stated under 42 U.S.C. § 1983, we reverse and remand for further proceedings consistent with this opinion.

The Supreme Court has held that 42 U.S.C. § 1983 can provide a cause of action in federal court for the denial of

rights created by a federal statute. *Maine v. Thiboutot*, 448 U.S. 1, 4, 100 S. Ct. 2502, 2504, 65 L.Ed.2d 555 (1980). *Thiboutot* has been narrowed as applied to some federal statutes, *see Middlesex County Sewerage Auth.* [*v.*] *National Sea Clammers Ass'n*, 453 U.S. 1, 19, 101 S. Ct. 2615, 2625, 69 L.Ed.2d 435 (1981); *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1, 28, 101 S. Ct. 1531, 1545, 67 L.Ed.2d 694 (1981). However, *Thiboutot* still governs actions brought to compel participating states to comply with the provisions of the Social Security Act. Specifically, in this and other circuits, actions which properly allege violations of 42 U.S.C. § 1396a(a)(13)(A) are entitled to consideration on the merits. *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291, 1295-96 (8th Cir. 1985); *Washington State Health Facilities Ass'n v. State of Washington Dep't of Social & Health Servs.*, 698 F.2d 964, 965 and n.4 (9th Cir. 1982); *Yapalater v. Bates*, 494 F.Supp. 1349, 1357-58 (S.D.N.Y. 1980), *aff'd*, 644 F.2d 131 (2d Cir. 1981), *cert. denied*, 455 U.S. 908 (1982); *Thomas v. Johnston*, 557 F. Supp. 879, 902-04 (W.D. Tex. 1983).

The district court relied primarily on *Pennhurst* to dismiss plaintiffs' action. It concluded that because the language of 42 U.S.C. § 1396a(a)(13)(A) is directed mainly to allocating Medicaid program funding obligations among state and federal sources, the statute did not create rights in favor of plaintiffs that are enforceable under § 1983. We disagree. *Thiboutot* rather than *Pennhurst* governs this case, and it was not necessary to engage in a *Pennhurst* analysis. Even if *Pennhurst* properly applies here, these plaintiffs can enforce 42 U.S.C. § 1396a(a)(13)(A).

Pennhurst established two exceptions limiting the effect of *Thiboutot* on cases involving the enforcement of federal statutory rights. Access to a § 1983 remedy should be denied if (1) the language of the statute indicates a congressional intent to foreclose § 1983 enforcement by making alternative

remedies available, or (2) the statute does not create "rights" enforceable by private parties under § 1983. *Almond Hill School v. United States Dep't of Agric.*, 768 F.2d 1030, 1035 (9th Cir. 1985); *Keaukaha-Panaewa Community Ass'n v. Hawaiian Homes Comm'n*, 739 F.2d 1467, 1470-71 (9th Cir. 1984); *Boatowners & Tenants Ass'n v. Port of Seattle*, 716 F.2d 669, 671 (9th Cir. 1983).

With respect to the first exception, the focus should be on the "comprehensiveness" of a statute's remedial scheme. Specific and detailed procedures for administrative and judicial review are more likely to foreclose or preclude recourse to § 1983. *See Almond Hill School*, 768 F.2d at 1035. Here, Title XIX permits states to establish administrative review procedures for disputes over Medicaid reimbursements. However, the statute does not provide for formal federal or state judicial or federal administrative review procedures. Indeed, in some cases, judicial review of such matters has been achieved only by permitting an "implied" right of action to be drawn out of the language of the statute itself. *See California Hosp. Ass'n v. Schweiker*, 559 F. Supp. 110 (C.D. Cal. 1982), *aff'd*, 705 F.2d 466 (9th Cir. 1983)(42 U.S.C. § 1396a(a)); *California Hospital Ass'n v. Obledo*, 602 F.2d 1357 (9th Cir. 1979)(42 U.S.C. § 1396a(a)(13)(A)).[1]

Although state violations of Title XIX may be remedied by means of the cut off of federal funding for a state's programs, this generalized remedial opportunity is not sufficiently precise to preclude remedies otherwise properly available under § 1983. *SeeKeaukaha-Panaewa*, 739 F.2d at

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[1] It is not a bar to a § 1983 action that a private right of action cannot be "implied" from the federal statute itself. *Keaukaha-Panaewa*, 739 F.2d at 1470. Rather, an independent § 1983 inquiry is required because " 'there could well be federal rights enforceable under section 1983 which are not enforceable by means of a private right of action under the statute creating them.' " *Id.* (quoting *Boatowners*, 716 F.2d at 674).

1471.[2] We conclude that the first *Pennhurst* exception should not bar this action.

The second *Pennhurst* exception examines the character of the "right" created by a federal statute. In *Boatowners*, we indicated that a useful method to determine whether a statutory "right" is sufficiently important for § 1983 enforcement is to borrow from the "implied" right of action line of authority. *Boatowners*, 716 F.2d at 672. In essence, we examine whether a statute meets the first of the four elements required by *Cort v. Ash*, 422 U.S. 66, 95 S. Ct. 2080, 45 L.Ed.2d 26 (1975), for recourse to private enforcement under an "implied" right of action theory. *Boatowners*, 716 F.2d at 672. The first *Cort* element considers whether a statute was enacted for the special benefit of a plaintiff or a plaintiff class. Borrowing from *Cort*, this circuit has stated that if a plaintiff is one of a class for whose special benefit a statute was enacted, and if Congress has not expressly proscribed private actions to enforce the benefit, the entitlement will support a plaintiff's § 1983 action. *Keaukaha-Panaewa*, 739 F.2d at 1471; *Boatowners*, 716 F.2d at 673, 672-73 (citing *Cort v. Ash*, 422 U.S. 66, 95 S. Ct. 2080, 45 L.Ed.2d 26 (1975)); *Fisher v. City of Tucson*, 663 F.2d 861, 863 (9th Cir. 1981), *cert. denied*, 459 U.S. 881, 103 S. Ct. 178, 74 L.Ed.2d 146 (1982).

Plaintiffs in this action are a private health-care facility and individual Medicaid patients residing in the facility. Patients confined by illness, disability, or age to a long-term health-care facility are intended beneficiaries of the Medicaid statutes in general and 42 U.S.C. § 1396a(a)(13)(A)

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[2] We decline to review the state administrative procedures and contractual remedies assertedly available to plaintiffs under Oregon law. In a § 1983 *Pennhurst* analysis, we are bound to consider only those remedial procedures established by the federal statute in issue. Complementary state procedures and remedies are not relevant.

in particular. Private health-care providers caring for Medicaid patients, such as Coos Bay Care Center, also have a direct financial interest in the availability of Medicaid reimbursement. In several similar cases, courts have permitted providers to bring actions to enforce the Medicaid statutes. *California Hosp. Ass'n v. Obledo*, 602 F.2d 1357 (9th Cir. 1979); *Massachusetts Gen. Hosp. v. Weiner*, 569 F.2d 1156 (1st Cir. 1978); *California Ass'n of Bioanalysts v. Rank*, 577 F.Supp. 1342, 1347 n.6 (C.D. Cal. 1983). These cases have recognized that Medicaid patients and health-care providers have parallel interests with respect to Medicaid funding and reimbursement. No reason has been advanced to justify the denial of a health-care provider's right to stand as co-plaintiff with individual Medicaid recipients in this action.

We do not suggest that plaintiffs in this action necessarily will prevail on the merits of their claim. We do not reach the merits. Rather, we hold simply that statutory rights under Title XIX of the Social Security Act have been alleged in the complaint which are sufficient to state a claim under 42 U.S.C. § 1983. To prevail on the merits, plaintiffs must convince the trial court that the actions and non-action of the State of Oregon violate the standard set out in 42 U.S.C. § 1396a(a)(13)(A). We do not reach the other issues raised in this appeal.

Reversed and remanded.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

[names of counsel omitted in printing]

COOS BAY CARE CENTER, an Oregon Corporation, (Guardian Ad Litems); HANNAH SCHWANKE, Guardian Ad Litem, for David and Steven Schwanke; and SANDY MAUER, et al,	)	Civil No. 84-6178-C
Plaintiff,	)	ORDER
v.	)	
STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD in his official capacity as Administrator of the Senior Services Division of the Department of Human Resources,	)	
Defendants.	)	

After a *de novo* review of the file in this matter, I adopt the Magistrate's Findings and Recommendation filed April 8, 1985.

This matter was heard by telephone conference on May 22, 1985, Mr. Hall standing in for Mr. Lojek appeared with Mr. Saalfeld for plaintiffs, and defendants were represented by Assistant Attorney General Thomas K. Elden. After oral argument and being fully advised in the premises, I stated that

I approved and adopted the Findings and Recommendation of the Magistrate *in toto* and held that the Complaint and action be dismissed. Counsel for plaintiffs indicating that they do not require an opportunity to replead, it is hereby

ORDERED that plaintiffs' Complaint including the class action allegations therein is dismissed with prejudice and without leave to amend.

[signature omitted in printing]

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

COOS BAY CARE CENTER, an Oregon Corporation, (Guardian Ad Litem); HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer, on their own behalf and on behalf of a similarly situated class of individuals,	)	
Plaintiffs,	)	Civil No. 84-6178-C
v.	)	FINDINGS AND RECOMMENDATION
STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD, in his official capacity as Administrator of the Senior Services Division of the Department of Human Resources,	)	
Defendants.	)	

[Attorneys names omitted in printing]

HOGAN, Magistrate:

This is a class action for alleged violations of plaintiffs' rights under the U.S. Constitution and other state and federal laws with a pendent state claim for alleged breach of con-

tract. Plaintiffs seek damages as well as declaratory and injunctive relief.

In essence, plaintiffs contend that the Coos Bay Care Center is under OAR 411-70-030 and a contract with the Senior Services Division of the state of Oregon Department of Human Resources, entitled to more money for services rendered to certain persons eligible for state and federal medical assistance.

Defendants now move the court for an order pursuant to Fed. R. Civ. P. 12(b)(1), 12(b)(6) and 12(e) dismissing plaintiffs' complaint for failure to state a claim and lack of jurisdiction, and, in the alternative, to make certain portions of the complaint more definite and certain.

The following background is essential to an understanding of the issues in this case. Plaintiff Coos Bay Care Center is an intermediate care facility providing long-term health care services for the developmentally disabled and the aged that participates in the 42 U.S.C. § 1396(a) et seq. (Title XIX) Medicaid program. Medicaid is a jointly funded federal-state program designed to render health care services to the poor. Under the program, the cost of maintaining a Medicaid patient is paid by the state, which in turn receives partial reimbursement from the United States Department of Health and Human Services. Approximately two-thirds of the cost of the program is met by the federal government, with the remainder coming from Oregon legislative appropriations. Participating health care providers, such as plaintiff, were formally [*sic*] paid under a cost reimbursement system, whereby the provider was reimbursed a percentage of its costs based on its census of Medicaid patients. Thus, for example, if the patient population of a long-term health care facility was comprised of fifty percent private paying patients and fifty percent Medicaid patients, then fifty percent of the providers cost would be met by the state of Oregon. This

system was mandated by federal law effective July 1, 1976. Social Security Amendments of 1972, Public Law No. 92-603, Section 249. The reimbursement system was changed in 1980 by the Omnibus Reconciliation Act of 1980 (Pub. Law. 96-499) which eliminated the requirement that the state pay for Title XIX health care services on a reasonable cost related basis. The new statutory standard requires that participants in the Medicaid program be paid through the use of established rates determined in accordance with methods and standards developed by the state and

> which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide case [*sic*] and services in conformity with the applicable State and Federal laws, regulations and quality and safety standards. . . . 42 U.S.C. § 1396a(a)(13)(A).

As noted *supra*, plaintiffs' complaint contends that under the applicable state regulation and a contract with the state of Oregon Department of Human Resources, plaintiff Coos Bay Care Center is entitled to more money for the services it renders to certain heavy care Medicaid patients, who by virtue of their medical or developmental problems require significantly more care that [*sic*] the ordinary intermediate patient. OAR 411-70-030 provides *inter alia* for specific and complete reimbursement of costs for providing heavy care. The individual plaintiffs contend that they are among the "heavy care" patients residing within the Coos Bay Care Center and elsewhere who qualify for heavy care but do not receive the full range of appropriate care because of defendants' alleged refusal to appropriately reimburse health care providers for such care.

I. *Plaintiffs' first cause of action alleges that defendants' conduct "violates 42 U.S.C. § 1396(a) et seq. and 42 CFR § 447.252."*

Defendants contend that the Medicaid statutes and regulations create no substantive, enforceable rights and move to dismiss plaintiffs' first cause of action pursuant to *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981) and *Beecroft v. Atiyeh*, No. 78-1027-BU (D.Or. April 16, 1982).

In *Pennhurst*, *supra*, the Supreme Court held that the Developmentally Disabled Assistance Bill of Rights Act of 1975 (42 U.S.C. § 6000 et seq.) did not create any substantive rights for the mentally retarded. The court's rationale was that nothing in the overall or specific purpose of the Act revealed an intent to require states to fund new substantive rights or to impose upon the states the obligation to fund certain levels of treatment.

Judge Burns apparently applied a similar rationale in *Beecroft*, *supra*, wherein he held

> *Pennhurst* shows that an examination of a statute's language structure and legislative history assist in determining when a right is created. *Id.* at 1540. In the instant case, these indicate no enforceable rights were created by Title XIX.
>
> Title XIX is basically a federal/state funding statute. Its language shows that its purpose is to assist the states in funding systems they develop and supervise. It says nothing of creating new, substantive rights for any individual or class. Its structure reflects administrative procedures and program requirements, not broad declarations of individual rights. Likewise, the legislative history does not indicate an intent to create rights. Thus, no substantive rights were created under either statute. *Beecroft*, *supra*, at 8.

In addition, Judge Burns held that no private right of action, expressed or implied, may be claimed under the Medicaid act or the regulations promulgated thereunder. Therefore,

assuming arguendo that Title XIX and its statutes and regulations create substantive rights, previous authority in this district indicates none of the plaintiffs herein have a private right of action to enforce those rights.

While according Judge Burns "due respect" and acknowledging his "scholarly and concise analysis" of *Pennhurst*, plaintiffs disagree with his conclusion in *Beecroft* and contend that the case of *Maine v. Thiboutot*, 448 U.S. 1 (1980) mandates an opposite conclusion than that reached by Judge Burns.

Although plaintiffs' argument is cogent and somewhat persuasive, I decline to "overrule" Judge Burns, who considered *Maine v. Thiboutot* in *Beecroft* and directly addressed the precise issue presented in the case at bar and decided it against plaintiffs' position. I follow *Beecroft* and find that plaintiffs are precluded from asserting a cause of action for alleged violations of Title XIX.

Because I find the foregoing issues dispositive, I need not address defendants' third argument with regard to plaintiffs' alleged failure to exhaust state administrative remedies.

Defendants' motion to dismiss plaintiffs' first cause of action should be granted.

II. *Plaintiffs' third cause of action alleges that defendants' conduct violates plaintiffs' constitutional rights pursuant to 42 U.S.C. § 1983.*

Defendants move to dismiss plaintiffs' third cause of action on the ground that no claim for relief has been stated.

Plaintiffs allege that they have been deprived of property without due process. To state a claim for deprivation of procedural due process rights under the Fourteenth Amendment, plaintiffs must establish the existence of some "life, liberty or property" interest within the meaning of the due process clause. *Ingraham v. Wright*, 430 U.S. 651 (1972). To have such a protected property interest a person must have

more than an abstract need or desire for it or unilateral expectation of it. He must have a "legitimate claim of entitlement to it." *Board of Regents v. Roth*, 408 U.S. 564 (1972) at 561.

As noted *supra* in *Beecroft*, Judge Burns concluded that Title XIX created no substantive rights and held that plaintiffs were precluded from attempting to "enforce" Title XIX by way of 42 U.S.C. § 1983.

Therefore, neither the residents of the Coos Bay Care Center nor the Center itself have a "legitimate claim of entitlement" to an increased funding level or a different funding mechanism.

Defendants' motion to dismiss plaintiffs' third cause of action should be granted.

III. *Plaintiffs' second cause of action is a pendent state claim under Oregon law for alleged breach of contract.*

Plaintiffs contend that defendants are in breach of the May 5, 1982, agreement between the Coos Bay Care Center and the state of Oregon to provide care as an intermediate care facility.

Defendants contend that plaintiffs' second cause of action is jurisdictionally barred by the Eleventh Amendment.

I need not address the merits of the parties' argument with respect to the application of the state of Oregon's immunity under the Eleventh Amendment.

Despite defendants' assertion to the contrary, I find that plaintiffs' second cause of action is a pendent state claim. Pursuant to my findings above, no basis for federal jurisdiction exists in this case. Although the court has discretion to retain jurisdiction over pendent state claims after dismissing federal claims, I find that it is not appropriate to do so in the case at bar. I find that the state courts of the state of Oregon are a more appropriate forum for the resolution of

plaintiffs' breach of contract cause of action. Accordingly, plaintiffs' second cause of action should be dismissed.

CONCLUSION

Based on all of the foregoing, defendants' motion to dismiss plaintiffs' complaint (#9) should be granted. Plaintiffs' complaint should be dismissed in its entirety as to all defendants. Defendants' alternative motion to make more definite and certain should be denied as moot.

DATED this 28th day of March, 1985.

[Signature omitted in printing]

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

DORCUS BEECROFT, et al.,	)	
	)	
Plaintiffs,	)	Civil No.
	)	78-1027-BU
v.	)	
	)	
VICTOR ATIYEH, in his official capacity as Governor of Oregon; LEO HEGSTROM, in his official capacity as Administrator of Human Resources Department; KEITH PUTMAN, in his official capacity as Director of the Division of Adult and Family Services; WILLIAM BROWN, in his official capacity as Assistant Director of the Division of Adult and Family Services; and J.H. TRELEAVEN, M.D., Administrator of the Mental Health Division,	)	OPINION
Defendants.	)	

HISTORY

This suit represents a challenge to Oregon's reimbursement of private intermediate care facilities for the mentally retarded (ICR/MR). It began in November of 1978 when plaintiffs, residents of Suislaw [*sic*] Care Center (one of the

private Large Residential Treatment Facilities in Oregon), sought declarative and injunctive relief from the state's reimbursement formula.

The reimbursement formula, developed by Oregon to comply with federal law, sets the rate at which the state reimburses private facilities for the shelter and care of plaintiffs and other similarly situated individuals. The challenged formula replaced the state's prior practice of reimbursing for the actual cost of all services, a more generous arrangement.

Plaintiffs, four residents of Siuslaw, contend that their rights established by federal law were violated by the Model Budget Plan (the state's reimbursement formula), which seriously reduced the amount of reimbursement. Their facility, Siuslaw, had received approximately $74 per resident per day during the latter half of 1977 and into 1978. Under the Model Budget effective November 1, 1978, Siuslaw's reimbursement fell to less than $39 per resident per day.

This reduction, they maintain, occasioned a substantial reduction in services and a frustration of the congressional intent to normalize the living environment of the retarded and the developmentally disabled. Specifically, plaintiffs assert that the reduced compensation hindered the transition from large state institutions to less restrictive, more responsive community-based facilities which the federal government intended to foster.

Historically, institutionalization had been society's primary response to the mentally retarded. In Oregon this had meant confinement to state institutions, Fairview or Eastern Oregon State Hospital. The state provided basic necessities; but little was done to train, educate or otherwise prepare the mentally retarded for a life in a different setting.

Beginning in 1972 through Title XIX of the Social Security Act of 1972, as amended, 42 U.S.C. § 1396 et. seq. (Title XIX), the federal government offered to assist states in

developing alternative approaches for treating the mentally retarded. The objective was to enhance the process of normalization and to provide shelter in the "least restrictive environment." The program sought to create environments, Intermediate Care Facilities/Mentally Retarded (ICR/MR), where individuals would be allowed to make decisions without the restrictions imposed by large institutions. In theory, the retarded persons would be encouraged and assisted to gain the skills necessary to move into progressively less restrictive environments.

To this end, Title XIX made available federal funds to states wishing to provide small community-based facilities. When the program started, Oregon's state facilities, as stated, then consisted of Fairview (about 1,400 residents) and Eastern Oregon State Hospital (about 375 residents). Few community-based facilities existed. The introduction of this program, however, spurred the growth of community facilities in Oregon. By early 1978 there were eleven such community facilities, in addition to Fairview and Eastern Oregon State Hospital.

Under federal regulations, states participating in the Title XIX assistance program are required to reimburse qualified providers (ICF/MR) for the "reasonable cost" of their care. A facility requesting reimbursement is audited by the state and allowed its "reasonable cost." Before the present Model Budget Plan went into effect November 1, 1978, providers in Oregon were reimbursed for the actual costs incurred without an upper limit.

By late 1977, it was apparent that the number of facilities and the unexpectedly high costs being incurred, would produce a serious deficit in the program's 1977-79 state budget (July 1, 1977 - June 30, 1979). As a result, a task force of Oregon officials was formed to study the situation and to

prepare a reimbursement scheme which would avoid or ameliorate the projected deficit.

This task force developed the Model Budget Plan, which governed the state's reimbursement policies. The Model Budget recognizes three separate types of facilities: SRFTs [*sic*], Small Residential Treatment Facilities (less than 15 residents comparable to group homes); LRTFs, Large Residential Treatment Facilities (15 to 200 residents, the community-based facility, of the type in which plaintiffs reside); and FSRTF, Full Service Residential Treatment Facilities (the state institutions of Fairview and Eastern Oregon State Hospital).

For each a "base cost," excluding salaries, was established. "Base cost" is the cost of funding comparable nursing homes with an additional percentage (10% of LRTFs and 5% for SRTFs) added as compensation for the special needs of the mentally retarded. In the LRTF involved in this litigation, the base cost is the non labor expense of running an institution with less than 200 beds.

The base cost is multiplied by the number of residents and the number of days in the month, and that amount is paid by the state to each facility as "provider payments." Under Title XIX, the federal government reimburses a state for these provider payments through federal matching funds. Reimbursement, however, is conditioned upon compliance with a variety of federal regulations including approval of a state reimbursement plan.

This state plan must be approved before a state contracts with qualified providers to furnish care and shelter. In turn, the ICF/MR facilities must comply with standards specified by the federal and state governments; reimbursement is conditioned upon compliance.

Congress established an administrative structure to regulate and implement reimbursement. Reimbursement is keyed

to an approved state formula. It is Oregon's reimbursement formula which plaintiffs challenge.

ISSUES

Plaintiffs maintain the method adopted by Oregon for reimbursement is invalid due to substantive and procedural defects. Plaintiffs claim these defects violate their rights under both Title XIX and the Developmentally Disabled Assistance and Bill of Rights Act of 1975, 42 U.S.C. § 6000 et. seq., DABRA. Specifically plaintiffs claim:

First, the Model Budget Plan does not:

(A) comply with the federal objective of enhancing normalization or providing the least restrictive environment.

(B) reimburse Siuslaw on the basis of "reasonable costs."

Second, the Model Budget Plan was adopted without consultation with the State Medical Care Advisory Commission as mandated by federal regulation.

Third, as a pendent claim, plaintiffs assert:

(A) the Model Budget Plan was promulgated without requisite notice and comment required by Oregon law.

(B) any such notice was a sham since the agency decided upon the Model Budget prior to what comment was received.

Before the substance of plaintiffs' complaint is considered, however, the defendants' challenge to this court's jurisdiction must be resolved. Because my jurisdictional ruling is dispositive, I do not rule on plaintiffs' substantive claims.

JURISDICTION

Federal courts are courts of limited jurisdiction. Subject matter jurisdiction must be established. Absence of jurisdiction is not waivable, Rule 12 (h)(3), Fed.R.Civ.P.

In the instant case plaintiffs, suing as private litigants, assert federal question jurisdiction based upon a violation of

rights they maintain are granted by federal statutes. Defendants deny jurisdiction because plaintiffs have been deprived of no right secured by the laws of the United States.

A private right of action is not the traditional means by which a state's noncompliance with a federal regulation is corrected. The ordinary remedy for noncompliance was for the federal government to cut off funding. A private action was permissible only if it were expressly or impliedly allowed by the underlying statute.

Recently, however, the Supreme Court in *Maine v. Thiboutot*, 448 U.S. 1 (1980), held that § 1983 actions may be used to redress deprivations of rights secured by federal statutory as well as constitutional law. Even if no private right of action exists under the substantive statute, § 1983 may still authorize a private suit.

However, a year after *Thiboutot*, the Court in *Middlesex County Sewerage Authority v. National Sea Calmmers* [*sic*], ___ U.S. ___, 101 S.Ct. 2615 (1981) the Court [*sic*] indicated that some distinction may exist between actions brought under § 1983 and a private right of action. In *Middlesex* the Court characterized § 1983 actions as "obviat[ing] the need to consider whether Congress intended to authorize private suits to enforce these particularly federal statutes." *Id.* at 2625.

Whatever may be the distinction between a § 1983 action and a private right of action, such is of no importance in the instant case because I consider both and find neither available.

42 U.S.C. § 1983 Actions

Section 1983 provides:

> "Every person who, under color of any statute, ordinance, regulation, custom, or usage, of the State of Territory, subjects or causes to be subjected, any

> citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges or immunities secured by the Constitution and laws shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress."

In *Maine v. Thiboutot*, 448 U.S. 1 (1980), the Court construed § 1983 as authorizing private suits against state officials who violate rights created by federal statute.

On its face plaintiffs' claim appears to fall within *Thiboutot* as an action under § 1983 alleging state action violative of federal rights secured by Title XIX and DABRA. However, in the year and a half since *Thiboutot* the Court has recognized two important exceptions to the application of § 1983 to statutory violations.

In *Pennhurst State School and Hospital v. Halderman*, ___ U.S. ___, 101 S.Ct. 1531 (1981) and later in *Middlesex County Sewerage Authority v. National Sea Clammers*, ___ U.S. ___, 101 S.Ct. 2615 (1981) the Court held that a § 1983 is unavailable if:

> (1) Congress foreclosed private enforcement of a statute as a result of the remedy provided by [the] enactment itself.
>
> (2) the substantive statute did not create any enforceable "rights" under § 1983.

In *Pennhurst* the Court held that the underlying federal statute, the Developmentally Disabled Assistance and Bill of Rights Act of 1975, 42 U.S.C. § 6000 et. seq., did not create any substantive rights for the mentally retarded. Finding no conferral of rights, the Court avoided the question of whether a private cause of action was alternatively available.

Two months later in *Middlesex* the Court reiterated the *Pennhurst* exceptions, relying on the second exception that an exclusive statutory remedy within the substantive statute foreclosed any § 1983 claim. As a result, the Court did not

reach (as it had in *Pennhurst*) the question of whether any substantive rights were created.

Those decisions demonstrate that a § 1983 action will not succeed unless a private litigant establishes both a substantive right and the absence of an exclusive remedy within that statute. Plaintiffs' claim fails when subjected to those tests.

(1) *Statutory Creation of a Substantive Right,*

42 U.S.C. § 1983 creates no enforceable rights. *Maher v. Gagne*, 448 U.S. 122 (1980); *Chapman v. Houston Welfare Rights Organization*, 441 U.S. 600 (1979); nor, inherently, does any federal statute. An enforceable right must be established by the terms of the underlying statute.

Whether enforceable rights were created by the statutes plaintiffs claim under is determined by *Pennhurst State School and Hospital v. Halderman*, ___ U.S. ___, 101 S.Ct. 1531 (1981). It is instructive for two reasons: First, its holding eliminates plaintiffs' claim under the Developmentally Disabled Assistance Act, leaving only Title XIX as a source of statutory rights. Second, the *Pennhurst* rationale refutes the argument that Title XIX creates enforceable rights.

Pennhurst shows that an examination of a statute's language structure and legislative history assists in determining when a right is created. *Id.* at 1540. In the instant case these indicate no enforceable rights were created by Title XIX.

Title XIX is basically a federal/state funding statute. Its language shows that its purpose is to assist the states in funding systems they develop and supervise. It says nothing of creating new, substantive rights for any individual or class. Its structure reflects administrative procedures and program requirements, not broad declarations of individual rights. Likewise, the legislative history does not indicate an intent to create rights. Thus no substantive rights were created under either statute.

(2) *Foreclosure of Private Enforcement*

A claim under § 1983 is also eliminated if the underlying statute provides for comprehensive remedial actions.

> "When the remedial devices provided in a particular act are sufficiently comprehensive, they may suffice to demonstrate Congressional intent to preclude the remedy of suits under § 1983."

Middlesex, supra, at 2626.

An examination of the "remedial devices" contained in Title XIX (the Developmentally Disabled Assistance Act having been eliminated as a source of rights by the *Pennhurst* decision) reveals an obvious rejection of judicial involvement. The statute provides for the termination of funding as the means of redress. There is no authorizaton of a private suit.

Judicial intervention is particularly inappropriate since compliance is monitored administratively at both the federal and state level. The program's structure requires long-range planning, periodic evaluation and swift enforcement—functions for which litigation is ill-suited. Given the history and structure of the congressional scheme, it is doubtful that Congress intended judicial intervention (particularly at the behest of a private litigant) as the means of redress.

Plaintiffs can not [*sic*] maintain a § 1983 action in the instant case based upon an alleged violation of their equal protection rights. The mentally retarded do not constitute a suspect class so as to trigger strict scrutiny under the Fourteenth Amendment. The applicable constitutional standard under the equal protection clause is whether the challenged state action rationally furthers a legitimate state purpose or interest. *San Antonio Indepedent* [*sic*] *School District v. Rodriquez*, 411 US. 1 (1973); *McGinnis v. Royster*, 410 U.S. 263 (1973). While the policy decision underlying Oregon's Model Budget Plan may be questioned, it cannot be said that the

plan is irrational nor that it is not intended to further legitimate state interest.

Private Right of Action

I find no private right of action, either express or implied, to be available to the plaintiffs under the following analysis.

(1) *Express Private Right of Action*

Plaintiffs can not [*sic*] claim an express right of action under either Title XIX or the Developmentally Disabled Assistance Act. Neither contains an express authorization of a private suit. The procedures and sanctions provided to ensure compliance do not include litigation. Disapproval of a state's plan or the termination of funds are stated remedies. No other cause of action is recognized.

(2) *Implied Private Right of Action*

In *Cort v. Ash*, 422 U.S. 66 (1975), the Supreme Court set forth four criteria for determining if a statute implied a private right of action:

> First: Is the plaintiff "one of the class for whose benefit the statute was enacted?"
>
> Second: Is there any indication of legislative intent, explicit or implicit, either to create or deny such a remedy?
>
> Third: Is it consistent with the underlying purposes of the legislative scheme to imply a remedy?
>
> Fourth: Is the cause of action one traditionally relegated to state law, in an area basically the concern of the states, so that it would be inappropriate to infer a cause of action based solely on federal law?

Applying these criteria, I find no implied private right of action for the following reasons:

> (1) While plaintiffs are within the "class" for whose benefit the statutes were enacted, any right must conform to the legislative intent and scheme. As the Court noted in *California v. Sierra Club*, ___U.S. ___, 101 S.Ct. 1775, 1779 (1981), "The question is not

simply who would benefit from the Act, but whether Congress intended to confer federal rights upon those beneficiaries.["] *Pennhurst* states that no conferral of rights was intended within the Developmentally Disabled Assistance Act, as does an analysis of Title XIX (see above).

(2) Legislative intent can be gleaned from the legislative history or statutory language. Here the legislative history is silent. Similarly, the statutory language shows that administrative rather than judicial enforcement is anticipated. Under Title XIX the state bears the responsibility of developing the program, of determining eligibility and of insuring that "care and services" will be provided "in the best interest of the recipients," 42 U.S.C. § 1396a (a)(17)(19), with no provision for federal judicial review.

(3) While the "underlying purpose" of both statutes is to benefit individuals, it does so indirectly, through financial assistance to states who choose to participate. While imposing certain federal standards, the intent is to minimize federal involvement by giving the states the administrative responsibility. To imply a private cause of action would be contrary to that intent. As Judge Krupansky observed in *Fuzio v. Manor Care, Inc.*, 461 F.Supp. 689, 697 (1977):

"A private right of action, utilized to enforce specific, limited portions of federal regulations on an ad hoc basis, would circumvent the responsibility of the state to administer its plan on [*sic*] an organized manner 'consistent with simplicity of administration and the best interests of the recipients,' 42 U.S.C. § 1396(a)(19), transferring the primary obligation in such cases from the administrative personnel intended to bear it to the federal courts."

(4) Plaintiffs challenge the state's policy decision as to the allocation of its resources. This is not an area amenable to judicial intervention. It involves a subject within the dominion of the state, traditionally relegated to state law. A state is free to budget funds

according to its priorities unless it violates individual rights. Any objection to a state's decision is best left to state officials.

Upon consideration of the above factors, I conclude that no implied right to private action exists. This is in keeping with the decisions of the Ninth Circuit, including the recent decision in *Community Psychiatric Centers of Oregon, Inc. v. Grant*, 664 F.2d 1148 (9th Cir. 1981).

CONCLUSION

The structure of this litigation and the alignment of the parties complicated this case. While residents of Siuslaw are ostensibly the plaintiffs, in reality the beneficiary would be the facility in which they reside. The rights plaintiffs claim are not theirs to assert.

Plaintiffs do not sue for the denial of a direct payment due them, as in *Thiboutot*, nor do they allege unsanitary conditions threatening their well-being, as in *Pennhurst*.

Instead, they challenge the reimbursement system which compensates the facility for their care while simultaneously acknowledging that facility's compliance with all federal and state standards.

This challenge is based, however, on rights not given them by law. I find that neither Title XIX nor the Developmentally Disabled Assistance and Bill of Rights Acts confers rights enforceable in this court. While those laws are directed at improving plaintiffs' condition, they set goals rather than create rights. Without such rights there is no federal question and thus this court has no jurisdiction.

Those goals seek to normalize the lives of the mentally retarded and to do so in the least restrictive environment. The intent is definite and admirable. But beyond legislative intent lies the task of program development and implementation.

Having articulated its standards and goals, Congress left to the states the task of designing an effective means of accomplishing them. Each state acts within the limits of its own budget and allocates its resources as it sees fit. Some will be more successful than others. Our system of government fosters that experimentation and views as beneficial the diversity inherent in a federal system.

In reviewing Oregon's response, this court must not impose its personal standards or beliefs. Only if the plan transgressed the law or violated constitutional rights should it be set aside. I find that such is not the case. It is uncontested that Siuslaw was in full compliance both before and after the imposition of the Model Budget Plan. Plaintiffs' own witnesses so testified. This is buttressed by the federal government's review and approval of the Model Budget Plan.

Before trial defendants submitted a motion to dismiss which was deferred until after a trial to the court, in which both sides presented evidence. Having reviewed that evidence and the arguments articulated by counsel's briefs, I find that for the above reasons this court lacks jurisdiction over plaintiffs' claims and I therefore grant defendants' motion to dismiss.

It is so ORDERED.

DATED this 16 day of April, 1982.

[signature omitted in printing]

[1] The Supreme Court held that the Developmentally Disabled Assistance and Bill of Rights Act did not create any substantive rights to "appropriate treatment" in the "least restrictive" environment for the mentally retarded. *Pennhurst* at pp. 1536-1547.

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OREGON

[List of attorneys omitted in printing]

COOS BAY CARE CENTER, an Oregon corporation, (Guardian Ad Litems); HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer, on their own behalf and on behalf of a similarly situated class of individuals,	)	Case No. _____
Plaintiffs,	)	COMPLAINT FOR BREACH OF CONTRACT; VIOLATION OF FEDERAL CONSTITUTION AND STATUTES; CLASS ACTION AND DEMAND FOR JURY TRIAL
vs.	)	
STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD in his official capacity as Administrator of the Senior Services Division of the Department of Human Resources,	)	
Defendants.	)	

COME NOW, Plaintiffs, by and through their attorneys of record, PARKINSON, LOJEK & PENLAND, CHARTERED, and HARLAND, RITTER, SAALFELD & GRIGGS, and for their cause of action against the Defendants, complain and allege as follows:

1. Plaintiff, Coos Bay Care Center, Inc., is an Oregon corporation with its principal place of business in Coos Bay, County of Coos, Oregon.

2. The named Plaintiffs are Hanna Schwanke and Sandy Mauer, Guardians Ad Litem, respectively, for David and Steven Schwanke and Tami Mauer, who are heavy care patients at the Coos Bay Care Center, Coos Bay, Oregon. All named Plaintiffs are Oregon residents.

3. Title XIX of the Social Security Act, as amended, commonly known as "Medicaid," provides for medical assistance to the indigent and developmentally disabled in the form of a cooperative program between each of the participating states and the United States of America.

4. Defendant, Department of Human Resources, pursuant to Oregon Revised Statutes 184.750 and 441.060, is an agency of the State of Oregon and is responsible for administering the Title XIX medical assistance program within the State of Oregon.

5. Defendant, Richard C. Ladd, is the person responsible for the administration of the State of Oregon, Department of Human Resources, and, at all material times hereto, has acted under color of state law.

6. The jurisdiction of the Court is invoked pursuant to 28 U.S.C. § 1331. The Plaintiffs' claims arising under Oregon law as more particularly stated herein are within the pendent jurisdiction of the Court since they arise out of a common nucleus of facts with the federal claims presented herein and are of such a nature that the Plaintiffs would ordinarily be expected to try all such claims in one proceeding.

7. Coos Bay Care Center, Inc. is engaged in the principal business of providing long-term care to the developmentally disabled and to the aged.

8. Coos Bay Care Center, Inc. is a licensed Intermediate Care Facility under the laws of the State of Oregon and has been so licensed at all material times hereto.

9. Coos Bay Care Center, Inc. on the 5th day of May, 1982, entered into an agreement with the Defendant State of Oregon, Department of Human Resources, Senior Services Division, for providing care under the Oregon Title XIX medical assistance program as an Intermediate Care Facility. A copy of the aforesaid agreement between Plaintiff, Coos Bay Care Center, Inc., and the Defendants is attached to this Complaint as Exhibit "A".

10. Plaintiffs David and Steven Schwanke and Tami Mauer are third party beneficiaries of this agreement and may maintain an action upon it.

11. The aforesaid agreement, *inter alia*, compels Coos Bay Care Center, Inc., (provider) and the Defendants to comply with applicable federal regulations as more particularly set forth at 42 C.F.R. § 442.300 and 42 C.F.R. § 442.250 and other regulations, as adopted.

12. The aforesaid agreement further obligates the Defendants to make payments to the provider in accordance with all federal and Oregon Administrative Rules applicable to Intermediate Care Facilities under the Title XIX Long-Term Care Facility Services Program existing within the State of Oregon.

13. The Title XIX program is established by the Social Security Act, as amended, 42 U.S.C. § 1396a *et seq.* and Oregon has chosen to participate therein. This program makes the State of Oregon responsible for the administration of state funds and the federal contribution under Title XIX of the Social Security Act, as amended.

14. Oregon has established a Medical Assistance Program (Medicaid) within the State which compels compliance with the State's own statutory terms and conditions thereof as well as all applicable regulations promulgated by the Department of Health and Human Services of the United States of America.

15. 42 U.S.C. § 1396a(a)(13)(A), particularly, provides that the state plan adopted by each state must contain

assurances satisfactory to the Secretary of the Department of Health & Human Services that established rates of reimbursement to participating medicaid providers are determined in accordance with methods and standards developed by the state and are reasonable and adequate to meet the costs which must be incurred by those providers who are efficiently and economically operated as they provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards.

16. Further, 42 C.F.R. § 447.252(a) provides that the single state agency responsible for administering the medicaid program within that state must pay for long term care rendered under the medical assistance program at a level which is sufficient to meet the costs which must be incurred by an efficiently and economically operated long term health care facility.

17. Additionally, § 411-70-030, of the Department of Human Resources, Senior Services Division, Nursing Facility Services Guide for Title XIX Medical Assistance Programs, provides, *inter alia*, for specific and complete reimbursement for provision of heavy cost care.

18. "Heavy care" patients are those who, by virtue of their medical or developmental problems, require significantly more or greater care than does the ordinary intermediate patient.

19. The heavy cost rates must include and reimburse for all nursing staff services, food or food substitutes, dressings, catheters and other special supplies as detailed in Rules 411-70-085 and 411-70-090.

20. The heavy cost rate does not include certain medical services as stated in Regulation 411-70-030(7)(a). Heavy cost care patients may be eligible under this rule and covered by rates for reimbursement in accordance with the rule.

21. There are now and have for some time been a number of patients at the Coos Bay Care Center, and at other similar

institutions within the State of Oregon, who are eligible for heavy cost care.

22. Patients at Coos Bay Care Center have been duly certified by physicians who have executed a Heavy Care Assessment and who have certified that the needs of the patient conform to the aforesaid rules and regulations of the Senior Services Division of the Department of Human Resources, State of Oregon.

23. In spite of the qualification of the patients, the State of Oregon and Defendant Richard C. Ladd, acting under color of state law, have developed an unconstitutional de facto policy procedure, custom and usage of consistently and repeatedly refusing to pay the cost of the heavy care patients to and on behalf of the Plaintiffs, thus denying them due process of law guaranteed by the Fifth and Fourteenth Amendments to the Constitution of the United States of America and resulting in a taking of property for public use without just compensation. Accordingly, the Plaintiffs' wards, David and Steven Schwanke and Tami Mauer, and the class they represent do not receive the quantity or quality of care guaranteed to them constitutionally and by state and federal laws, statutes and regulations as aforesaid, although Plaintiff Coos Bay Care Center does afford "heavy care" patients as much "heavy care" as possible.

24. Throughout the State of Oregon there are other heavy care patients residing within long-term health care facilities who similarly qualify for heavy care but who do not recieve the full amount of appropriate care because of the refusal of the Defendants to appropriately reimburse health care providers for such care.

CLASS ACTION ALLEGATIONS

25. Plaintiffs therefore bring this action pursuant to Rule 23 of the Federal Rules of Civil Procedure on their own behalf and on behalf of all other residents of licensed long term health care facilities within the State of Oregon who, as a

result of Defendants' actions, or non-action, have not been granted full medical assistance commensurate with their status as heavy care patients as more particularly described below.

26. The number of heavy care patients in the Plaintiff class is so numerous that the joinder of all members of the class is impracticable. Upon information and belief, the named Plaintiffs aver that the number of heavy care patients in the proposed class exceeds 100 patients, statewide.

27. The claims of the representative Plaintiffs are typical of the Plaintiff class and arise out of identical facts constituting the unlawful conduct of the Defendants. The representative Plaintiffs will fairly and adequately protect the interests of the Plaintiff class.

28. This action may be maintained as a class action pursuant to Rule 23(a)(2) of the Federal Rules of Civil Procedure since Defendants have acted and refuse to act on grounds generally applicable to the Plaintiff class, thereby making appropriate final declaratory relief with respect to the class as a whole.

29. This action may be maintained as a class action pursuant to Rule 23(b)(3) of the Federal Rules of Civil Procedure since the questions of law and fact common to the claims of the Plaintiff class and resulting from Defendants' actions predominate over any questions affecting only individual members. The successful assertion of the claims of the named Plaintiffs necessarily establish determinations of fact and law adequate to prove the unlawful actions of Defendants, thereby making a class action superior to any other available method for the fair and efficient adjudication of the claims of the named Plaintiff class.

FIRST CAUSE OF ACTION

30. Plaintiffs hereby incorporate and reallege paragraphs 1 through 29 in this paragraph as if fully set forth herein.

31. The aforesaid course of conduct by the Defendants violates 42 U.S.C. § 1396a *et seq.* and 42 C.F.R. § 447.252.

32. As a direct and proximate result of the violation of these statutes and regulations the Plaintiffs have been damaged in the approximate amount of $138,600.00 and will continue to be irreparably damaged in the amount of the differential between the heavy cost care afforded and routine care.

SECOND CAUSE OF ACTION

33. Plaintiffs hereby incorporate paragraphs 1 through 29 in this paragraph as if fully set forth herein.

34. The aforesaid course of conduct by the Defendants constitutes a breach of contract by the Defendants.

35. As a proximate result of this breach of contract the Plaintiff Coos Bay Care Center has been damaged in the amount of $138,600.00 and will continue to be damaged on a daily basis. Plaintiffs Schwanke and Mauer and the class they represent will continue not to be afforded the full measure of heavy cost care to which they are entitled.

THIRD CAUSE OF ACTION

36. Plaintiffs hereby incorporate paragraphs 1 through 29 in this paragraph as if fully set forth herein.

37. The aforesaid course of conduct by the individual Defendants constitutes a violation of 42 U.S.C. § 1983 in depriving the Plaintiffs of their constitutional rights under the Fourteenth Amendment of the United States Constitution and their statutory rights, both state and federal, as aforesaid.

38. As a proximate result of the violation of Plaintiffs' constitutional rights, Plaintiff Coos Bay Care Center has been damaged in the amount of $138,600.00 and Plaintiffs Mauer, Schwanke and each member of the class they represent have been damaged in the amount of $10,000.00.

39. Plaintiffs hereby claim all necessary and proper attorney's fees in accordance with 42 U.S.C. § 1988.

WHEREFORE, Plaintiffs pray for relief as follows:

1. For a declaratory judgment of this Court that those medicaid patients in Oregon long term health care facilities who are certified as heavy care patients be recognized as such by the State of Oregon in accordance with the rules and regulations of the State of Oregon and the United States, Department of Health & Human Services, and that those long-term health care facilities who provide care to such patients be reimbursed appropriately.

2. For a further order from this Court to direct the Defendants to conform to the aforesaid Federal statutes and regulations in their reimbursement methodology in the administration of the Medicaid program.

3. For a further declaratory judgment that the agreement between Plaintiff Coos Bay Care Center and the State of Oregon has been breached by the State and that the Plaintiffs have been and are being damaged thereby.

4. For an injunction prohibiting the Defendants from violating federal and state law, as alleged.

5. For damages pursuant to 42 U.S.C. § 1983, in the amount of $138,600.00 to Plaintiff Coos Bay Care Center which represents the lack of appropriate reimbursement from May 26, 1982, to the date of judgment, and for an award of $10,000.00 each to the other named Plaintiffs and to each member of the class they represent.

6. For Plaintiffs' attorney's fees, costs and expenses reasonably incurred in bringing this cause of action pursuant to 42 U.S.C. § 1988 and the Federal Rules of Civil Procedure.

7. For such other and further relief as to this Court seems just.

Dated this 27th day of April, 1984.

[Signatures omitted in printing]

APPENDIX F

Heavy Cost Care

411-70-030 (1) Resident Eligibility: To be eligible for payment under the Heavy Cost Program, the resident must:

(a) Meet the definition of functional quadriplegia (see subsection (2)(b) of this rule);

(b) Be a person ready for discharge from an acute care hospital or whose care could be provided in a nursing facility in lieu of placement in an acute care hospital (see subsection (3)(d) of this rule);

(c) Have prior approval of the local Division or Type B Area Agency on Aging Pre-Admission Screening Team Registered Nurse (see subsection (6)(a) of this rule).

. . . .

(7) Rates:

(a) The heavy cost rate will include all nursing staff services, food or food substitutes, dressings, catheters and other special supplies, as detailed in rules 411-70-085 and 411-70-090. The heavy cost rate does not include those medical services, i.e., physician, physical therapy, pharmacy, dental, etc., paid through Title XIX, Title XVIII, Veterans Administration, etc., and personal incidental items authorized for payment from the client's personal incidental allowance. (See rule 411-70-095)

(b) The amount of the heavy cost rate will be on add-on to the facility's established rate for the client's level of care.

APPENDIX G

All-Inclusive Rate

411-70-085 (1) The skilled and/or semi-skilled rate established for a facility includes all services, supplies, and facility equipment required for care. This rule *does not apply to*: medical care services by outside providers paid through Title XIX Medical Assistance funds, Title XVIII, VA, etc.; and personal incidental items authorized for payment from the client's personal incidental allowance.

(2) The following types of items and services are included in the all-inclusive rate (the fact that the provider may customarily make a separate charge to private residents is irrelevant):

(a) All nursing and supportive care services including restorative nursing care.

(b) Room, board, and laundry (including laundry of residents' bedding and clothing whether performed by the facility or an outside provider).

(c) Items which are routinely furnished to all residents without additional cost.

(d) Items stocked by the facility in gross supply and administered individually on physician's order.

(e) Items owned or rented by the facility which are utilized by individual residents but which are reusable and expected to be available in a nursing facility.

(f) Non-legend, over-the-counter pharmaceuticals *not* listed in the basic drug formularies in Adult and Family Services Division's **"Guide for Pharmaceutical Services"**. (See rule 411-70-090, Payment for Medical Care and Services, section (1).)

(g) Shaves, haircuts, and shampoos as required regularly for grooming and cleanliness must be provided by the facility. These are included in the all-inclusive rate whether performed by facility staff or outside providers.

APPENDIX H

Rate Setting Per Diem Rate

411-70-440 (1) The maximum per diem rates for skilled nursing facilities and intermediate care facilities will be established by the Division effective January 1 of each year. The rates will be based on financial statements received by the Division by September 30 which cover fiscal periods ending in the last full fiscal year of the Division (July 1 through June 30). The financial statements will be desk reviewed or audited by the Division and the resulting total allowable per diem costs for each type of facility will be arrayed in rank order from the lowest total per diem cost to the highest total per diem cost. A similar array of total allowable indirect per diem costs including both types of facilities will be established.

(2) The Division has established the 75th percentile ranking from lowest to highest total allowable per diem costs as the maximum per diem rate needed to reimburse an efficiently and economically operated facility. The Division has also established the 75th percentile ranking from the lowest to the highest total allowable indirect per diem costs as the maximum indirect per diem rate.

APPENDIX I

Definitions

461-09-000 (1) Whenever used in this Division, or in any amendment or supplement thereto, unless otherwise specified, the following terms shall have the meanings herein stated:

(1) A "claimant" is a person:

(a) Seeking an opportunity to sign an application for public assistance;

(b) Who has applied and is awaiting the agency's decision on that application;

(c) Whose application has been approved;

(d) Receiving assistance or whose assistance payment has been reduced, suspended, discontinued or the manner of payment is changed to a protective, vendor or two-party payment;

(e) Still considering himself/herself entitled to assistance;

(f) Who is aggrieved by any other agency action affecting his/her receipt or termination of assistance;

(g) Who was denied or excluded from an AFS service program.

(2) A "contested case" is a case in which:

(a) A constitutional provision or an agency enabling act requires a hearing upon the action; or

(b) The agency has discretion to suspend; or

(c) There is a proceeding in which the agency by rule or order provides for a hearing, in accordance with contested case requirements.

(3) A "hearing" is an informal contested case proceeding before an impartial hearings official appointed by AFS. The claimant of public assistance or his/her representative may present all pertinent facts and evidence to show why action or inaction in his/her case should be reconsidered by AFS.

(4) A "request for a hearing" is a written expression received by the Division within 30 days from the date of notice on an Administrative Hearing Request form completed by the claimant or by any person acting in his/her behalf, describing the agency action or issue he/she desires to contest.

(5) The "date of the request" is:

(a) The date the completed and signed Administrative Hearing Request form is received in the AFS branch office; or

(b) The date the first oral or written request was received in the AFS branch office provided:

(A) The claimant or his/her representative complete and sign an Administrative Hearing Request form; and

(B) The Administrative Hearing Request form is received in the AFS branch office within fifteen (15) calendar days from the date of notice.

(6) "Handicap" is a physical or mental impairment which substantially limits one or more major life activities, a record of such impairment, or the state of being regarded as having such an impairment.

The Hearing Request

461-09-010 (1) Any claimant of public assistance or service payments has the right to request a hearing in relation to any action on his/her claim or failure to act on his/her claim by a branch office/unit/agency at any time. Only the Chief Hearing Officer can dismiss the request as specified in rule 461-09-060.

(2) A hearing may be requested at any time prior to written notice where the branch office/unit/agency has failed to act on a claim.

(3) A request for a hearing is not complete until the Administrative Hearing Request form is completed and signed by the claimant or the claimant's representative, and received by the branch office/unit/agency.

(4) The applicant for public assistance has the right to request a hearing if after 45 days there has been no formal action on his/her application.

(5) Any person who has a handicap has the right to request a hearing when he/she feels he/she has been wrongfully denied benefits or services, or has been otherwise subjected to discrimination because of the handicap.

(6) Every request for a hearing shall be given prompt attention to assure that definite and final administrative action is taken. The Hearings Unit shall immediately acknowledge, in writing, the receipt of an Administrative Hearing Request form to both the claimant and to the branch office/unit/agency. The acknowledgement to the claimant shall describe the procedure followed in hearings. The branch office/unit/agency may, at any time, reconsider its decision in the light of current circumstances, and advise the claimant of any change in its decision.

Group Fair Hearings

461-09-011 The Hearings Unit may respond to a series of individual requests for hearings by conducting a single group hearing. Hearings may be so consolidated in cases when the sole issue is a Division policy. If recipients request a group hearing, the Hearings Unit will grant it. Each individual has the right to withdraw from the group hearing in favor of an individual hearing.

Appeals

411-70-435 A certified letter will be sent notifying the provider of the year-end settlement. The provider shall notify the Division in writing within 15 days of receipt of the letter if the provider wishes to appeal the settlement. Letters must be postmarked within the 15-day limit.

APPENDIX J

183.482 Jurisdiction for review of contested cases; procedure; scope of court authority. (1) Jurisdiction for judicial review of contested cases is conferred upon the Court of Appeals. Proceedings for review shall be instituted by filing a petition in the Court of Appeals. The petition shall be filed within 60 days only following the date the order upon which the petition is based is served unless otherwise provided by statute. If a petition for rehearing has been filed, then the petition for review shall be filed within 60 days only following the date the order denying the petition for rehearing is served. If the agency does not otherwise act, a petition for rehearing or reconsideration shall be deemed denied the 60th day following the date the petition was filed, and in such cases, petition for judicial review shall be filed within 60 days only following such date. Date of service shall be the date on which the agency delivered or mailed its order in accordance with ORS 183.470.

(2) The petition shall state the nature of the order the petitioner desires reviewed, and shall state whether the petitioner was a party to the administrative proceeding, was denied status as a party or is seeking judicial review as a person adversely affected or aggrieved by the agency order. In the latter case, the petitioner shall, by supporting affidavit, state the facts showing how the petitioner is adversely affected or aggrieved by the agency order. Before deciding the issues raised by the petition for review, the Court of Appeals shall decide, from facts set forth in the affidavit, whether or not the petitioner is entitled to petition as an adversely affected or an aggrieved person. Copies of the petition shall be served by registered or certified mail upon the agency, and all other parties of record in the agency proceeding.

(3)(a) The filing of the petition shall not stay enforcement of the agency order, but the agency may do so upon a showing of:

(A) Irreparable injury to the petitioner; and

(B) A colorable claim of error in the order.

(b) When a petitioner makes the showing required by paragraph (a) of this subsection, the agency shall grant the stay unless the agency determines that substantial public harm will result if the order is stayed. If the agency denies the stay, the denial shall be in writing and shall specifically state the substantial public harm that would result from the granting of the stay.

(c) When the agency grants a stay it may impose such reasonable conditions as the giving of a bond or other undertaking and that the petitioner file all documents necessary to bring the matter to issue before the Court of Appeals within specified reasonable periods of time.

(d) Agency denial of a motion for stay is subject to review by the Court of Appeals under such rules as the court may establish.

(4) Within 30 days after service of the petition, or within such further time as the court may allow, the agency shall transmit to the reviewing court the original or a certified copy of the entire record of the proceeding under review, but, by stipulation of all parties to the review proceeding, the record may be shortened. Any party unreasonably refusing to stipulate to limit the record may be taxed by the court for the additional costs. The court may require or permit subsequent corrections or additions to the record when deemed desirable. Except as specifically provided in this subsection, the cost of the record shall not be taxed to the petitioner or any intervening party. However, the court may tax such costs and the cost of agency transcription of record to a party filing a frivolous petition for review.

(5) If, on review of a contested case, before the date set for hearing, application is made to the court for leave to present additional evidence, and it is shown to the satisfaction of the

court that the additional evidence is material and that there were good and substantial reasons for failure to present it in the proceeding before the agency, the court may order that the additional evidence be taken before the agency upon such conditions as the court deems proper. The agency may modify its findings and order by reason of the additional evidence and shall, within a time to be fixed by the court, file with the reviewing court, to become a part of the record, the additional evidence, together with any modifications or new findings or orders, or its certificate that it elects to stand on its original findings and order, as the case may be.

(6) At any time subsequent to the filing of the petition for review and prior to the date set for hearing the agency may withdraw its order for purposes of reconsideration. If an agency withdraws an order for purposes of reconsideration, it shall, within such time as the court may allow, affirm, modify or reverse its order. If the petitioner is dissatisfied with the agency action after withdrawal for purposes of reconsideration, the petitioner may file an amended petition for review and the review shall proceed upon the revised order. If an agency withdraws an order for purposes of reconsideration and modifies or reverses the order in favor of the petitioner, the court shall allow the petitioner costs, but not attorney fees, to be paid from funds available to the agency.

(7) Review of a contested case shall be confined to the record, the court shall not substitute its judgment for that of the agency as to any issue of fact or agency discretion. In the case of disputed allegations of irregularities in procedure before the agency not shown in the record which, if proved, would warrant reversal or remand, the Court of Appeals may refer the allegations to a Master appointed by the court to take evidence and make findings of fact upon them. The court shall remand the order for further agency action if it finds that either the fairness of the proceedings or the correctness of the

action may have been impaired by a material error in procedure or a failure to follow prescribed procedure.

(8)(a) The court may affirm, reverse or remand the order. If the court finds that the agency has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall:

(A) Set aside or modify the order; or

(B) Remand the case to the agency for further action under a correct interpretation of the provision of law.

(b) The court shall remand the order to the agency if it finds the agency's exercise of discretion to be:

(A) Outside the range of discretion delegated to the agency by law;

(B) Inconsistent with an agency rule, an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency; or

(C) Otherwise in violation of a constitutional or statutory provision.

(c) The court shall set aside or remand the order if it finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding.

183.484 Jurisdiction for review of orders other than contested cases; procedure; scope of court authority. (1) Jurisdiction for judicial review of orders other than contested cases is conferred upon the Circuit Court for Marion County and upon the circuit court for the county in which the petitioner resides or has a principal business office. Proceedings for review under this section shall be instituted by filing a petition in the Circuit Court for Marion County or the circuit court for the county in which the petitioner resides or has a principal business office.

(2) Petitions for review shall be filed within 60 days only following the date the order is served, or if a petition for reconsideration or rehearing has been filed, then within 60 days only following the date the order denying such petition is served. If the agency does not otherwise act, a petition for rehearing or reconsideration shall be deemed denied the 60th day following the date the petition was filed, and in such case petition for judicial review shall be filed within 60 days only following such date. Date of service shall be the date on which the agency delivered or mailed its order in accordance with ORS 183.470.

(3) The petition shall state the nature of the petitioner's interest, the facts showing how the petitioner is adversely affected or aggrieved by the agency order and the ground or grounds upon which the petitioner contends the order should be reversed or remanded. The review shall proceed and be conducted by the court without a jury.

(4)(a) The court may affirm, reverse or remand the order. If the court finds that the agency has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall:

(A) Set aside or modify the order; or

(B) Remand the case to the agency for further action under a correct interpretation of the provision of law.

(b) The court shall remand the order to the agency if it finds the agency's exercise of discretion to be:

(A) Outside the range of discretion delegated to the agency by law;

(B) Inconsistent with an agency rule, an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency; or

(C) Otherwise in violation of a constitutional or statutory provision.

(c) The court shall set aside or remand the order if it finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding.

(5) In the case of reversal the court shall make special findings of fact based upon the evidence in the record and conclusions of law indicating clearly all aspects in which the agency's order is erroneous.